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Unintentional Neglect in the Treatment of Surgical Diseases.

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UNINTENTIONAL NEGLECT IN THE TREATMENT OF SURGICAL DISEASES.*

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There is no reproach so severe in the eyes of a physician as the reproach of neglect; and indeed the man who is careless of the welfare of those intrusted to his keeping, who can lightly let slip any opportunity which might change favorably the course of disease, does not deserve fellowship in the noble brotherhood of medicine. Yet one of the commonest faults of the physician is a kind of unwitting neglect where action is delayed in cases of unrecognized or dimly suspected gravity. Such dangerous delays occur in the practice of all the branches of medicine, but I shall speak here only of a few of the diseases known as surgical, drawing my conclusions and citing instances entirely from personal experience.

First, then, cancer. This hideous malady, no matter where situated, is always a surgical disease. It is not in every case amenable to operation, but as yet no medicine

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has been of the slightest avail. On the other hand, complete timely removal of the diseased area is known to give promise of freedom from relapse. Yet the patient rarely consults the surgeon until systemic poisoning has occurred, the intervening time having been largely taken up with worse than useless attempts to cure the trouble with salves, internal medication, or by means of *faith*, the latter form of therapeusis doing, perhaps, less harm and giving more mental comfort than either of the others. This is all too frequently the fault of the physician. I confess it makes my blood boil to hear, as I often must, the diagnosis of malignancy deferred because there is "no cachexia." It seems to me very like waiting for uræmic convulsions or coma to establish the diagnosis of renal trouble.

Take, for example, cancer of the tongue. If one sees the case early, there is probably a small lump or even a flat ulceration which gives no pain. No lymph nodes are enlarged and the patient feels uneasy simply because he knows that the sore exists. Yet, if antisyphilitic dosing for a week and the removal of sharp or irritating teeth are not at once followed by noticeable improvement, the case is one for excision with a wide margin of apparently healthy tissue. The freezing microtome will enable a diagnosis to be made in a very few moments, when more extensive operation at the same sitting may, if necessary, be undertaken. It has been my lot to see cancer of the tongue treated nearly invariably too long for syphilis. Even if there is a history of this disease, it does not forbid the diagnosis of cancer, but makes it more probable. Cancer is prone to develop on a leucoplakial tongue.

Case I.—C. G., a gentleman forty-two years old, came to me about a year ago with a nasty, foul-smelling sore on the left side of his tongue near the tip. It was hard and was sloughing in the middle. An indurated lymph node could be plainly felt

near the left extremity of the hyoid bone. A sharp and jagged tooth seemed to be the irritating cause of the sore. For over seven months an energetic physician had treated this man with mercurial inunctions and iodide of potassium. He still insisted that because the man had said that he once had had a chancre the sore on the tongue must be syphilitic. So sure was he of his diagnosis that he had not even advised the extraction of the sharp tooth. This was done soon after I saw him, and I then removed the left half of the tongue, together with the enlarged glands of the neck. The disease was, however, so extensive that a relapse occurred in the neck within three months, and in half a year the man was dead. A common enough history, but it teaches a lesson which seems hard to learn, for all its simplicity.

Cancer of the breast is a disease which seems to cause more than its share of culpability among medical men. If there is one ailment above another where an early working diagnosis is easily made it is this one. Yet, how horribly often do we hear men give the advice to wait for this or that symptom, in the meantime quieting the poor patient with plasters and salves! It is bad enough to listen to doubts as to malignancy because the nipple is not retracted, or because there is no discharge or no immobility of the tumor; but when an apparently intelligent practitioner doubts the existence of a cancer until the armpit is invaded, what shall we say? Every recent graduate ought to know better than to look for such a sign. It is almost or quite as bad as to wait for a board of health report before instituting treatment in a malignant case of diphtheria.

Case II.—A stout woman, Mrs. C., thirty-eight years old, consulted me some months ago regarding a lump in her right breast. It had first been noticed a year before, and from that time she had been constantly under the eye of her physician. The treatment had been by medicines, lotions, etc. Finally, becoming a little suspicious, she came from her southern home to

New York for an opinion. I found a tumor as big as a large egg adherent to skin and muscle, with numerous enlarged lymph nodes in both axillæ. The woman was slightly corpulent and there was not a sign of cachexia. I amputated the left breast, with the axillary contents and the pectoral fascia, also removing a lymph node from the left armpit. It was cancerous. The friends of the patient, learning of the bad prognosis, advised against further operation and took her home to die.

The progress of this case had been slow, and I am sure its outcome would have been very different had the physician observed his patient for a month instead of for a year. Instead of insisting on an exploratory incision he pronounced the tumor "nothing." Bull has tersely referred to this very common soothing expression of opinion by the remark that "a lump in the breast is never a 'nothing.'" In the same paper (*Medical Record*, August 25, 1894) he has also called attention to the frequent malignant degeneration of innocent growths. The physician who sees a breast tumor early should, in these days of advanced and advancing medical education, consider himself responsible for results if he cause delay of more than four weeks in active methods of attack.

If we condemn delay in cancers which can be seen or easily felt, what shall we say of those where the trouble is situated internally, as, for example, in the stomach? The more progressive members of our profession, recognizing that the disease is one to be removed by operation where a sufficiently early diagnosis can be made, have bent all their energies toward accomplishing this early recognition, and very satisfactory progress is being made. The examination of the stomach contents by chemical and other means, the gastrodiaphane, and other modern instruments and methods should enable us to make up our minds as to the *necessity for exploratory incision* before a tumor is pal-

pable. If one waits until a tumor shall develop which is large enough to be felt, or until a stout patient shall have emaciated sufficiently to enable one to make satisfactory palpation, the case is already hopeless. If we are to have success in this field of surgery we must learn that early exploratory operation in suspicious cases is demanded. If on section nothing is found, then in these aseptic days the patient has risked little except a weakening of part of his abdominal wall, and if a cancer is found the conditions for its removal are better than they ever will be again. I have never seen a patient die of an exploratory section where no fatal disease was present, and I believe such cases must be exceedingly rare.

As an example of the waiting system, I may here refer to

Case III.—This was a case of carcinoma of the transverse colon in a man of about forty-two years, where for a whole year the patient was under medical observation (*N. Y. Med. Jour.*, September 1, 1894). He was operated upon by me, and the tumor, with about six inches of gut, removed. The man made a perfect recovery from the operation, and is still free from symptoms due to obstruction, but there will in all probability be a relapse by metastasis, for there were many infected lymph nodes in the mesentery which could not be removed. The growth was a very slow one, and was due to degeneration of an adenoma. A radical cure might have been hoped for had the operation taken place six months earlier.

Intestinal Obstruction.—The next class of cases for attention consists of those where there is obstruction of any part of the intestinal tract. These are urgently surgical, as Dr. J. B. Murphy has said, "as soon as the diagnosis is made." Yet I have seen operation postponed day after day because some symptom indicating the gravest danger was absent; such a sign, for example, as fæcal vomiting.

The fact is that when there is persistent vomiting of any kind, with abdominal pain and obstipation resisting high enemata, there must be present some anatomical, inflammatory, or neoplastic change demanding abdominal section. For the progress of the science of medicine I believe it may even be regarded as a misfortune when a patient gets well without operation where there has been foolish delay; for there are always illogical persons who will say that because A. B. got over an attack without the use of the knife therefore X. Y. ought to delay and not submit to operation. But it happens that A. B. suffered from fæcal impaction, while X. Y. has an intussusception which threatens gangrene. However, even X. Y. *may* recover without section by a medical miracle and without thanks to his physician.

I shall never forget one of the first patients on whom I operated for intestinal obstruction.

She was a young girl of nineteen years who was admitted to the hospital, having had no stool for five days. The attack began with a sudden sharp pain immediately after drinking a glass of cold water. There had been almost constant vomiting ever since. When I saw her the temperature was under 100° F., and the abdomen was soft. The girl was conscious and had no severe pain, but vomited incessantly. Had it not been for a wretched, feeble, and rapid pulse her general condition might have been called good. Enema by long tube was almost without result. There was no bloody discharge. It was nine o'clock in the evening. One of my friends, a well-educated practitioner, saw the case with me and advised against operation because of insufficient diagnosis. I disagreed with him, and, though I keenly felt the responsibility, I operated that night, being led to my decision by the patient's miserable pulse and by the vomiting, which, by the way, was not fæcal. Median abdominal section disclosed at once an immense intussusception involving more than two feet of gut. It was gangrenous, and I realized that the case was hopeless. Rapidly walling off the free abdominal cavity, I incised the whole mass to

relieve tension, but the girl died the next day. Cases like this have taught me that the gravest forms of intestinal obstruction may exist with little or no fever and without the classical sign of stercoraceous vomiting.

It was my intention to speak here of appendicitis, but the profession has been so long and persistently stirred up on the subject that it hardly seems possible that any one who reads the journals or attends medical meetings should err by delay in this disease. It may not be amiss to repeat, however, that appendicitis may exist without pain or tenderness in the right iliac region. Quite recently I saw two cases where fatal delay occurred because of the absence of this well-known symptom.

Empyema of the Mastoid.—This is far from a rare condition, and it is one of those where the percentage of neglect is perhaps higher than in any other disease. The pus is pent up in a region where spontaneous discharge, with the recovery of the patient, is almost an impossibility. It is, moreover, a region easily and very safely accessible to a skilled operator. Without evacuation, meningitis, thrombosis of the lateral sinus, pyæmia, or some combination of these deadly complications will surely occur. Yet, even in gravely suspicious cases, certain of the very men who make this part of the body the subject for special work and study will advise us to wait for *meningeal irritation*, which is simply the first step into truly dangerous territory.

I have yet to learn a satisfactory reason for delay where there has recently been middle-ear suppuration and where marked mastoid tenderness exists. If there is also fever, in spite of an open ear drum, the way is clear without waiting for any sign of extension of the disease. The stake is a heavy one, being nothing less than a human life; the risk of operation is a comparatively slight one. The opening

of a mastoid filled with pus is certainly not entirely devoid of danger, but is absolutely necessary; while, if no pus is present, the procedure is not a particularly perilous one, and it may be productive of good, as, for example, where the bone is sclerosed or eburnated.

I do not wish to go over the whole field of surgery in this strain. I have merely spoken of certain types of disease which are of daily occurrence, and I have tried to show that neglect, unintentional though it be, is a frightfully common fault. The reasons for its existence are various. Probably one of the most frequent is an exaggerated idea of the dangers of the operation itself. It is not that I would belittle the seriousness of major surgical work, but that I wish to emphasize the point that no operation is ever knowingly undertaken by a conscientious surgeon where he believes his remedy to be more dangerous than the malady which is to be attacked. It is a rare thing in these days for an operation to be performed where the surgeon might later wish he had stayed his hand. The opposite state of affairs is, however, unfortunately too frequent. The vast majority of patients afflicted with malignant chronic disease come to the knife in time for palliation at best. Too many cases of appendicitis are first seen by the surgeon when peritonitis or general sepsis already exists. Only too often is a suppuration of the mastoid cells permitted to go on to fatal meningitis under the very eye of the physician.

A few weeks ago I saw a woman who had been for several months treated with caustics and lotions for the cure of a fungating ulcer which began in a little mole on the heel. Her medical adviser disregarded the fact that after each application the granulations sprang up with increased vigor. The patient finally secured the services of a good diagnostician, who at once recognized malignancy and proposed the removal of the

growth. When he was about to operate, several skin nodules were found in the leg, and the woman was sent to the Mount Sinai Hospital for amputation of the thigh. It was here that I first saw her. Examination of one of the nodules showed the tumor to be melanotic myxosarcoma. The patient now refused to submit to operation and went home. At last accounts a regular (?) practitioner of this city had guaranteed a cure without the use of the knife.

Another reason for wrong delay may be ascribed to unscientific medical education and a consequent dependence on stereotyped combinations of symptoms learned from books, as a picture of disease. Such knowledge is parrot-like, and he who depends upon it must be misled and confused by any departure from the fixed nosological type. He is tempted to wait for what he considers a clearer expression of the disease as he has learned it, and the precious time is gone.

Accurate diagnosis is a scientific and most satisfactory thing. Treatment without diagnosis is foolish and often worse; but there is in surgical disease a golden middle way too seldom traversed where the Gordian knot may be loosed by means of the scalpel. I refer to the making of an intelligent *partial diagnosis*—that of "case for operation." I do not believe in carelessly opening the living human body as a child breaks his toy, just to see "what's inside," but if there are logical grounds to suspect that there is something inside which ought to come out, delay can rarely be productive of good.

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